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2 UNITED STATES DISTRICT COURT  
3 FOR THE DISTRICT OF COLUMBIA

4 UNITED STATES OF AMERICA, )  
et al., )  
5 ) Civil No. 18-2340  
Plaintiffs, )  
6 )  
v. )  
7 ) Washington, D.C.  
CVS HEALTH CORPORATION, ) June 4, 2019  
8 et al., )  
9 ) Day 1  
Defendants. ) Afternoon Session

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11 TRANSCRIPT OF MOTIONS HEARING  
12 BEFORE THE HONORABLE RICHARD J. LEON  
13 UNITED STATES DISTRICT JUDGE

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## E X A M I N A T I O N S

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NEERAJ SOOD	93			
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MICHAEL WOHLFEILER				
	133			
DIANA L. MOSS				

## E X H I B I T S

1 AFTERNOON SESSION

2 (2:10 P.M.)

3 THE COURT: The witness can resume the stand.

4 NEERAJ SOOD,

5 having been previously duly sworn, was examined and  
6 testified further as follows:

7 THE COURT: You remain under oath, Doctor.

8 You may proceed when you're ready.

9 MR. QUILLEN: Thank you, Your Honor.

10 DIRECT EXAMINATION

11 BY MR. QUILLEN:

12 Q. Before the lunch break, we had started to talk about  
13 potential efficiencies associated with this merger. And I  
14 believe you had started with the idea that the merger would  
15 promote innovation.

16 Do you want to pick up there.

17 A. Sure. Let me just -- if you will allow me to start  
18 with a quick summary of the arguments before the efficiency  
19 claims.

20 So with the merger and without the divestiture, what  
21 happens is, in every PDP market, we have loss of Aetna as a  
22 competitor, and in every PDP market, there is an increase in  
23 market concentration because CVS and Aetna were competing in  
24 every PDP market. With the divestiture now, we still have  
25 loss of Aetna as a competitor in every PDP market, and we

1 have an increase in market concentration in every PDP market  
2 because Aetna and WellCare were competing in each one of  
3 those 34 PDP markets. And we have discussed the evidence  
4 that the loss of a competitor and increasing market  
5 concentration will, the evidence says, lead to higher  
6 premiums.

7 So now let's focus on the efficiencies. We also  
8 discussed the efficiency claims within the PDP market, and we  
9 said that this is not a merger within the PDP market because  
10 with the divestiture Aetna and CVS are not merging in the PDP  
11 market. Therefore, there are no PDP market-specific  
12 efficiencies that can arise.

13 So now let's look at the efficiencies outside the PDP  
14 market and what they might be.

15 So the first efficiency we discussed, potential  
16 efficiency, which was claimed by CVS is this would promote  
17 innovation in healthcare delivery through these healthcare  
18 hubs. And I discussed that typically the way innovation  
19 should work is you innovate, and if consumers like what  
20 you've done, you're providing a service at a low cost and  
21 good quality, then you will attract more consumers. But what  
22 this seems like, it's backwards. What you did is you bought  
23 Aetna and its 20 million subscribers, and now you're going to  
24 try to funnel them or steer them to your new model of  
25 healthcare delivery but now these 20 million subscribers are

1 not available to other innovators who might have had better  
2 ideas or who could provide the same service at a lower cost  
3 or better quality.

4 So, for those innovators, these customers are absent,  
5 and those innovators will suffer as a result. So I don't  
6 think this will promote innovation, but it might actually  
7 lead to a decline in innovation in healthcare delivery.

8 The other proposed benefit of this is that they've  
9 said, look, we, at CVS, have access to pharmacy data, and now  
10 we're going to buy Aetna, which is a health insurer, so now  
11 we're going to have access to the medical data, and we can  
12 combine the pharmacy data and the medical data to, say,  
13 better design the drug benefit.

14 So one example of that would be, you know, suppose  
15 there's a drug that lowers your healthcare costs, so you want  
16 to provide good coverage for that drug if you're integrated  
17 because you know that even though it increases your expense  
18 on the drug side you lower your expense on the medical  
19 benefits side. But if you look at what Aetna says, Aetna  
20 says -- this is on slide 14 -- so Aetna says, when they  
21 sign -- so Aetna signed PBM services agreement with CVS. So  
22 this was about 10 years ago. And when they signed that  
23 agreement, they clearly said -- they said, we retain our PBM  
24 and our ability to integrate medical care with clinical and  
25 pharmacy programs and actionable data. So what they're

1 saying is they were already doing what they claimed to be  
2 efficiency specific to the merger. They already, without  
3 this merger, had the ability to integrate medical data with  
4 clinical and pharmacy programs.

5 So I don't see why this merger is needed to integrate  
6 the medical and pharmacy data. You could do it outside the  
7 merger.

8 As a professor at U.S.C. or as a healthcare  
9 researcher, when I do research on healthcare, I have access  
10 to combined pharmacy and medical data. So if I, as a  
11 researcher, can get access to it, I'm sure a big company like  
12 Aetna or CVS can get access to the merged data.

13 The other thing they said was, look, if you combine  
14 this medical and pharmacy data, we can make CVS's pharmacists  
15 more effective at counseling patients. Well, what I feel is,  
16 if you truly want to make a pharmacist more effective at  
17 counseling patients, what you need is the medical record  
18 data. You need the data from the patient's doctor. Like the  
19 healthcare claims data is just medical bills. They don't  
20 tell you the clinical detail that you would know to manage a  
21 patient. I'm no doctor, but I believe that if someone is  
22 counseling me, I want them to have my doctor's notes with  
23 them. This merger doesn't enable them to have those doctor's  
24 notes.

25 The third efficiency claim is -- if you think about



1       this, maybe CVS and Aetna integrate, and that makes CVS a  
2       better PBM for Aetna. But at the same time, when it creates  
3       incentives for CVS to be a better PBM for Aetna, through  
4       input foreclosure, it also creates incentives for CVS to be a  
5       worse PBM for any plan that is competing with Aetna.

6               Now, if you look at the number of beneficiaries CVS  
7       has, that's about 90 million that they represent in their PBM  
8       business. And roughly 20 million are Aetna subscribers. So  
9       these 20 million will potentially benefit because now CVS is  
10      going to be a better representative or a better PBM for  
11      Aetna. But the other 70 million are going to be worse off  
12      because those other 70 million potentially compete with CVS  
13      and Aetna in insurance markets and their CVS now has the  
14      incentive not to provide the same level of service as they're  
15      providing to Aetna. So, in some sense, there is a potential  
16      benefit to 20 million, but at the same time, there is a  
17      potential harm to 70 million.

18             Finally, suppose this benefit arises. How will it  
19      benefit the public? It will only benefit the public if the  
20      savings are passed back to the consumers as lower premiums.  
21      So the idea is CVS and Aetna are one firm. They come up with  
22      a better benefit design. That should lower premiums  
23      and -- that should lower their costs, but whether it lowers  
24      premiums or how much it lowers premiums depends upon  
25      competition in the insurance market. So if there isn't a lot

1 of competition in the insurance market, those cost savings  
2 will not be passed on to consumers, or some of them will be,  
3 but majority or a large fraction of those cost savings will  
4 not be passed on to consumers. But if the insurance markets  
5 are competitive, then a high fraction of those cost savings  
6 are passed on to consumers. And the evidence is that health  
7 insurance markets are very concentrated.

8 So given that, it is likely that a significant  
9 fraction of the savings will not be passed on to the  
10 consumers even if they arise.

11 Q. What does the economic literature say about whether  
12 previous mergers in the health insurance industry were good  
13 for consumers?

14 A. Sure. So, on slide 21, I have quoted what -- so in  
15 the *United States v. Anthem* case, several health economics or  
16 economics professors submitted an amicus brief which  
17 summarized the evidence on the effects of health insurance  
18 mergers, and I was one of the cosigners on the brief. It  
19 surveyed the entire literature in this area, and we were all  
20 independent professors, we were not representing either party  
21 in this case.

22 And the summary of that work says, "This body of work  
23 finds that consultation in health insurance markets does not  
24 on average benefit consumers. Although greater insurance  
25 market concentration tends to lower provider prices, there is

1 no evidence the cost savings are passed through to consumers  
2 in the form of lower premiums. To the contrary, premiums  
3 tend to rise with increased insurer concentration."

4 So what this is saying is, when insurers merge  
5 together, it increases their bargaining power with providers  
6 of input. So you do see some cost savings, but those cost  
7 savings are not passed to consumers.

8 In the end, what you see is that increase in market  
9 power as a result of this merger leads to an increase in  
10 premiums for consumers.

11 THE COURT: And an increase in profits?

12 THE WITNESS: And an increase in profits. Because if  
13 you're not passing on the savings to consumers, then those  
14 savings are going to represent increase in profits for you.

15 The other kind of quote I have is from the  
16 congressional testimony of Professor Martin Gaynor, who is  
17 one of the leading experts on healthcare policy or healthcare  
18 antitrust policy. And he talks specifically about efficiency  
19 claims related to healthcare mergers. So what he notes is,  
20 "While the intuition, and the rhetoric, surrounding  
21 consolidation has been positive, the reality is less  
22 encouraging. The evidence on the effects of consolidation is  
23 mixed, but it's safe to say that it does not show overall  
24 gains from consolidation. Merged hospitals, insurers,  
25 physician practices, or integrated systems are not

1 systematically less costly, higher quality, or more effective  
2 than independent firms."

3 So what he is saying is, across a whole variety of  
4 healthcare mergers, you don't see strong evidence that  
5 efficiency improves or costs go down.

6 And what the prior evidence was saying is, when  
7 insurers consolidate, there is strong evidence that premiums  
8 go up.

9 BY MR. QUILLEN:

10 Q. In your opinion, is there anything about the various  
11 markets in which CVS participates that would cause this  
12 merger to buck the trend that these researchers have  
13 identified?

14 A. I don't know of any such factor.

15 MR. QUILLEN: I have no further questions.

16 THE COURT: You may step down.

17 THE WITNESS: Thank you, Your Honor.

18 THE COURT: Thank you.

19 (Witness excused)

20 THE COURT: Who will present the next witness?

21 MR. BARLOW: I will, Your Honor.

22 THE COURT: All right.

23 MICHAEL WOHLFEILER,

24 having been duly sworn, was examined and testified as  
25 follows:

## 1 DIRECT EXAMINATION

2 BY MR. BARLOW:

3 Q. Dr. Wohlfeiler --

4 A. Hello.

5 Q. -- can you state your name, please, and spell it for  
6 the record.7 A. It is Michael, M-I-C-H-A-E-L, Wohlfeiler,  
8 W-O-H-L-F-E-I-L-E-R.

9 Q. And where are you employed, Dr. Wohlfeiler?

10 A. I'm employed with AIDS Healthcare Foundation.

11 Q. And you'll see on the table in front of you your CV.  
12 That is marked as AHF 1. That's your CV; correct?

13 A. Yes, that is.

14 Q. I'm going to talk about some of your background. I'm  
15 not going to go into great detail on it.16 But first off, what is the AIDS Healthcare  
17 Foundation?18 A. So AIDS Healthcare Foundation, or AHF, is a nonprofit  
19 organization that is a provider of medical care to patients  
20 with HIV or AIDS. We're what's called a safety net provider.  
21 We take patients regardless of their ability to pay.22 Q. Okay. Could you explain that safety net provider  
23 concept in more detail.24 A. So, again, a patient with HIV or AIDS who needs care  
25 is accepted at -- can receive care at AHF. It doesn't matter

1 if they have a payer source at the time. We will provide  
2 care. We will do our best to get them onto -- find a payer  
3 source for them.

4 The other thing that we do is we provide what are  
5 called wrap-around services. We provide a lot of additional  
6 services that you wouldn't find in, for instance, a private  
7 practice. We have a staffing model that our clinics have an  
8 RN on site, we have special positions called benefits  
9 counselors, and we have case managers, and referral  
10 coordinators; a lot of extra services that you would not  
11 normally find.

12 Q. The safety net provider status, is that pursuant to  
13 federal law?

14 A. Well, there is -- safety net provider is used in, for  
15 instance, the 340B -- what is called the 340B legislation,  
16 which specifically applies to nonprofit safety net providers  
17 like AHF and affects at what price we can purchase  
18 medications. It allows us to purchase medications for  
19 patients at a discounted price.

20 Q. Can you talk a little bit about AHF's operations in  
21 the United States?

22 A. Sure. We have been around for I think it is 31 years  
23 now. Started in Los Angeles as an AIDS hospice organization  
24 back in the days when HIV and AIDS was really a death  
25 sentence. And then, as things got better, AHF opened up

1 clinics to treat patients with HIV and AIDS. And then we  
2 consistently expanded so that now we've got over 60 clinics  
3 in 15 states and the District of Columbia. We're taking care  
4 of domestically about 35,000 patients. We've also got a  
5 global program where we're in more than 40 countries. And  
6 worldwide AHF is taking care of 1.1 million patients with  
7 HIV/AIDS.

8 Q. In addition to the roughly 60 clinics, do you also  
9 have a network of pharmacies?

10 A. Yes. Part of our model is that we have tried to  
11 create a one-stop shopping for patients, and we've also  
12 recognized the importance of the pharmacist-patient  
13 relationship. And so as a result, most of our clinics,  
14 unless they're very small and have a low census, have  
15 embedded within them an AHF pharmacy co-located.

16 Q. Co-located?

17 A. Yes.

18 Q. And your position with AHF currently is what?

19 A. So I'm Chief Medical Officer. As that, I run AHF's  
20 Domestic Department of Medicine, which means that I'm kind of  
21 ultimately responsible for all of the clinical care that we  
22 provide.

23 Q. And do you have firsthand knowledge of AHF's  
24 business?

25 A. I'm sorry? AHF's?

1 Q. Business overall?

2 A. Yes. Yes. Again, I run the Department of Medicine,  
3 but I am very familiar with our pharmacy business, our  
4 managed care business.

5 Q. Do you serve on any executive committees?

6 A. Yes. I serve on -- the executive committees are the  
7 highest level committees, and I serve on both managed care  
8 exec and pharmacy exec at AHF.

9 Q. How long have you been the Chief Medical Officer?

10 A. It will be six years in August.

11 Q. When did you join AHF?

12 A. I joined AHF in September of 2011.

13 Q. And you're a practicing physician?

14 A. Yes, I am. I'm a physician specializing -- in  
15 private practice -- specializing in HIV/AIDS since 1990.

16 Q. Are you a credentialed HIV/AIDS physician?

17 A. Yes. I'm credentialed as an HIV specialist by the  
18 American Academy of HIV Medicine.

19 Q. In addition to your executive duties with AHF, do you  
20 currently treat HIV/AIDS patients?

21 A. Yes, I still treat patients.

22 Q. Can you explain for the Court how the treatment of  
23 HIV and AIDS has evolved from the time you began practicing  
24 in 1990.

25 A. It's been a dramatic change. I mean, when I



1 started -- I really started seeing HIV patients during my  
2 residency in internal medicine, which I did in Miami, which  
3 was one of the epicenters of HIV. And back in those days, it  
4 was really felt that everybody who was HIV-positive would  
5 progress to AIDS and everybody with AIDS would die. And that  
6 was pretty accurate. I mean it was just nothing but death  
7 for many years. It truly was a death sentence. And we were  
8 just trying to keep patients -- extend their lives initially  
9 and, hopefully, give them slightly better quality of life.  
10 But there was no ability to really control the disease  
11 long-term in the early days.

12 Q. What is the current state of treatment that you're  
13 seeing --

14 A. It is very different. It started to change in around  
15 1996. And I would say it is really since the 2000s that  
16 things have changed dramatically. Now the vast majority of  
17 HIV patients can be placed on medication regimens, which  
18 typically involve at least three drugs, and we can -- we  
19 can't cure them, but we can get the virus suppressed to  
20 undetectable levels in their bloodstream, and that allows  
21 their immune system to repair and to stay relatively strong,  
22 and these patients can remain now stable. It has become a  
23 chronic illness.

24 Q. What is your purpose in testifying in these Tunney  
25 Act proceedings today?

1       A.       So we've got a model of care for HIV that works very  
2       well, and it includes our coordination between our providers,  
3       our clinics, our pharmacies. And frankly, I'm concerned that  
4       we're going to see our model imperilled by this behemoth  
5       merged organization and the power that it has.

6       Q.       And let me just back up on the clinic. So you say  
7       you have roughly 60. Are they served by physicians in those  
8       clinics?

9       A.       So we -- our medical providers are a combination of  
10      physicians and what are called -- have been called  
11      mid-levels, but the preferred term nowadays is advanced  
12      practice providers. So those would be nurse practitioners  
13      and physician assistants working under supervision of a  
14      physician.

15     Q.       And are the providers at these clinics credentialed?

16     A.       Yes. It's a requirement of employment at AHF that  
17      any provider who's not credentialed as an HIV specialist at  
18      the time of hire has to become credentialed within 12 to 18  
19      months of starting.

20     Q.       What about the pharmacists that are employed at your  
21      pharmacies; are they credentialed?

22     A.       Yes. So the American Academy of HIV Medicine also  
23      has a credentialing program for pharmacists, and our  
24      pharmacists are all credentialed as HIV pharmacy experts.

25     Q.       Now, can you talk a little bit about the health

1 insurance plans that AHF has.

2 A. So AHF's own plans you're talking about?

3 Q. Yes.

4 A. Okay. So what we have is, in California, Florida,  
5 and Georgia, AHF created Medicare managed care plans that are  
6 what are called SNPs or special needs plans. They're open  
7 only to patients with an HIV diagnosis. Then, in California,  
8 in addition, we have a Medicaid managed care plan.

9 Q. Can you expound a little bit more on what you call  
10 the wrap-around services, the continuum of care that AHF  
11 provides from the clinics to the pharmacies.

12 A. So we actually start even earlier with -- than the  
13 clinics with this kind of, you know, comprehensive continuum  
14 of care. We do more -- AHF does more HIV testing than  
15 anyplace else in the world, anyone else in the world. So if  
16 somebody tests positive for HIV at one of our testing sites,  
17 they immediately become part of our linkage program. A  
18 linkage counselor, who is somebody who's trained in HIV and  
19 dealing with patients, immediately contacts the patient,  
20 serves as support and education. And we have a standard that  
21 anybody who tests HIV-positive is seen in one of our clinics  
22 within 72 hours of their diagnosis. The linkage person will  
23 literally take them by the hand and walk them into the clinic  
24 if need be to get them initiated in care.

25 Once they're in the clinic, we practice

1 patient-centered, high-touch care. We provide these  
2 wrap-around services that, again, most patients who at the  
3 time their HIV diagnosis don't have private insurance or any  
4 other funding source, so they get an appointment with what's  
5 called a benefits coordinator to find out if they qualify for  
6 typically the Ryan White Program, which is a payor of last  
7 resort for patients with HIV or an ACA plan or a Medicaid  
8 plan. And so we get them benefits that way. We  
9 have -- because a lot of our patients have a lot of multiple  
10 comorbidities and are medically very complicated, we have --

11 Q. What do you mean by comorbidities?

12 A. Other medical conditions that are -- not just HIV.  
13 You see a higher rate of heart disease, diabetes, kidney  
14 disease, liver disease; a lot of different things in patients  
15 with HIV.

16 And so we have medical case managers, who are usually  
17 RNs, to help coordinate the care for these patients so that  
18 everything is being taken care of.

19 One of the things -- one of the other things that is  
20 unique about AHF is that what we practice is what I call HIV  
21 primary care. We discovered that patients just kind of  
22 naturally adopt their HIV treater as their PCP or primary  
23 care physician. So there's some places where there's someone  
24 who manages the HIV using an infectious diseases doctor but  
25 won't manage the cholesterol, the blood pressure, won't see

1 the patient if they've got a cold or the flu. We're the  
2 primary care doctors as well as the HIV specialist for our  
3 patients.

4 Q. Can you explain how important it is to make sure that  
5 HIV/AIDS patients adhere to their medication schedule. Talk  
6 about that.

7 A. I find frequently nowadays that -- I think people  
8 think -- a lot of people think that something has  
9 fundamentally changed about HIV as a disease, and it hasn't  
10 changed. I mean, untreated, it is still going to kill the  
11 vast majority of people who have the virus.

12 What's changed is that we have medications that can  
13 now keep the HIV under control. These medications, though,  
14 require a very high level of adherence. We know that, based  
15 on studies, that people who take chronic medications for  
16 other conditions, like say high blood pressure, that their  
17 adherence to the medications is usually 70 to 80 percent.  
18 Studies have shown that in HIV if you have less than a 95  
19 percent adherence to the anti-retroviral medications that the  
20 virus has the opportunity to activate, mutate, and become  
21 resistant to the medications, and then they won't work  
22 anymore. So adherence is a huge issue in this disease.

23 Again, we can't cure it, but if we keep the virus  
24 suppressed, not only does the patient stay healthy, but  
25 studies have shown the patient cannot transmit HIV to another

1 person. So there's not just a personal health issue for the  
2 infected patient but a major public health issue as well.

3 Q. You mentioned anti-retrovirals. Can you just explain  
4 that.

5 A. These are the medications that work through various  
6 mechanisms to block HIV from replicating and infecting other  
7 cells. So these are medications that are used only for HIV  
8 treatment. They're often complicated medications with  
9 potential side effects and drug interactions with other  
10 medications. So when you're talking about anti-retrovirals,  
11 you're really talking about the medications used to suppress  
12 HIV.

13 Q. In this model that AHF has to treat HIV and AIDS,  
14 does it work?

15 A. It works incredibly well. The CDC puts out data.  
16 There's something called the Gardner Cascade, and it is named  
17 after Dr. Gardner, and he did an analysis of the continuum of  
18 care starting with how many HIV-infected persons there are in  
19 this country to then how many of those people know their HIV  
20 diagnosis, how many have engaged in care, how many have been  
21 retained in care, and then ultimately how many have  
22 their -- and in how many is the virus suppressed, which is  
23 the goal. And numbers in the U.S. for that last step of the  
24 Cascade show somewhere between 30 and 50 percent of HIV  
25 patients in this country being consistently -- with their

1 virus being consistently suppressed. And at AHF our numbers  
2 are closer to 85 percent suppression.

3 Q. So roughly double the average --

4 A. Yes.

5 Q. -- national average?

6 What are the factors that make for a successful model  
7 would you say?

8 A. I mean, a big part of it is having high touch with  
9 the patients. They have actually done studies on retention  
10 and care amongst -- with HIV patients -- and have found that  
11 the more what they call touch points between the clinic, the  
12 staff in the clinic, the physician, you know, so forth, and  
13 the patient, the more likely they are to remain in care and  
14 remain on their medications. So that's a big part of what we  
15 do.

16 But then we also have very specific things that are  
17 very focused on adherence both to the anti-retroviral  
18 medications and to medical follow-up. So we have -- the  
19 pharmacy generates something called the 35-day report. And  
20 if a patient has not been in to pick up their medications  
21 within -- in the last 35 days, they track them down. And  
22 they find them, and they find out what's going on.

23 The other thing is that, at AHF, nobody will leave  
24 without their medications, no matter what the situation is.  
25 It doesn't matter if they can't afford the co-pay. It

1 doesn't matter if they have lost coverage. We do not let  
2 anything interrupt their care.

3 On the provider side, we have something called a  
4 104-day report, which is similar. But typically, HIV  
5 patients come in about every three months for blood work and  
6 evaluation by a provider. So if patients haven't been in  
7 within 104 days, then every provider every month is given a  
8 list of the names of those patients and are expected to  
9 personally call those patients and check on them and try to  
10 get them back in to be seen.

11 Q. And how important is it for the physicians to be  
12 specialists in HIV and AIDS for the treatment of AIDS?

13 A. That really is critical. Again, there are studies.  
14 Published studies have shown that there's a direct  
15 correlation between your risk of death from HIV and the  
16 experience of your medical provider. And so we put a big  
17 emphasis on making sure that our patients are -- I mean, our  
18 providers are credentialed as specialists, that they keep up  
19 with education. We have a monthly CME, continuing medical  
20 education program, that our providers are -- they're  
21 scheduled to block for it every month. It's live webcast to  
22 every provider in the country.

23 Q. And can you talk a little bit about how AHF protects  
24 the privacy of your patients.

25 A. Given that we are an organization that deals with



1 HIV, we are very, very focused on confidentiality. Though  
2 the stigma associated with HIV is much less overall than it  
3 used to be when I started in this, there's still a big  
4 stigma. Obviously, people want their diagnosis kept very  
5 confidential. So when we send out -- we ask every patient  
6 when they first come in whether it is okay for us to call  
7 them or text them, whether we can send them mail. And we  
8 never identify on the mail that it is AIDS Healthcare  
9 Foundation. We have -- a lot of our patients who are getting  
10 medication through our AHF pharmacies have those medications  
11 delivered, and we make sure that our delivery people -- they  
12 have IDs, but it doesn't say anything about AHF. To maintain  
13 confidentiality, sometimes patients who live with family or  
14 roommates don't want meds delivered to the house. The driver  
15 will literally meet them at a Starbucks, wherever they want  
16 to meet to give them their medication so as to maintain their  
17 privacy.

18 Q. Okay. Now I want to move to just talk a little bit  
19 more about AHF's role in the various levels of the market.  
20 You identified clinics, pharmacies, and health plans.

21 A. Uh-huh.

22 Q. So AHF competes in the pharmacy market with CVS; is  
23 that correct?

24 A. Correct.

25 Q. And they compete with Aetna as a health plan;

1 correct?

2 A. Yes.

3 Q. And they are a provider, they participate as a  
4 provider through the retail clinics; correct?

5 A. Yes.

6 Q. And as a pharmacy, AHF is a provider to CVS/Caremark  
7 as a PBM; correct?

8 A. Yes.

9 Q. You heard the testimony of Dr. Sood about the  
10 consolidation generally in the healthcare industry. Do you  
11 generally agree with what Dr. Sood said about the  
12 consolidation and concentration levels --

13 A. Yes --

14 Q. -- in the healthcare industry?

15 A. -- I do.

16 Q. Have you seen that even in your 30 years in the  
17 business, have you seen those trends of concentration  
18 increasing over the years?

19 A. Definitely. I mean I'm not quite sure how many years  
20 ago it was now, but we saw it with United and OptumRx  
21 becoming a single conjoined entity. I don't know if that was  
22 a merger or purchase or whatever it was. And almost  
23 immediately we saw our patients being told that they could no  
24 longer use the AHF pharmacy; that they were being forced into  
25 mail order programs for their medications. And it was a real

1 disruption of their continuity of care and emotionally was  
2 very difficult for a lot. I had patients in tears  
3 about -- our patients, just as they develop a strong  
4 relationship with the providers, they develop an equally  
5 strong relationship with the pharmacist and the pharmacy  
6 staff.

7 Q. In that instance, what was Optum/United telling these  
8 AHF patients in terms of whether they needed -- had to use  
9 mail order?

10 A. So they were being told that they had to start  
11 receiving their meds by mail order. And we -- I personally  
12 started dealing with numerous problems associated with that.  
13 I mean, one of the really frustrating things that I dealt  
14 with was -- you know, there would be a screw-up or something  
15 wouldn't get processed properly at the PBM, and a patient  
16 wouldn't receive his or her HIV medications, and I would get  
17 on the phone with the PBM and say, you know, get the problem  
18 straightened out. And say, this patient is going to be out  
19 of medication tomorrow, you need to overnight this to the  
20 patient.

21 And they would say, no, it takes 10 days.

22 And I'm like, but this is HIV. You don't understand  
23 it. They can't be off their medication for 10 days. That's  
24 dangerous. It puts them at risk of developing resistance to  
25 their medications.

1 Well, that's our policy.

2 You know, it was things like that.

3 And we had patients who were trying very hard to opt  
4 out of the mail order, and we were told at various times that  
5 patients had the right to opt out. But whenever they tried  
6 to do it, it never seemed to happen. Either they were told  
7 that they couldn't opt out despite what we had been told or  
8 there were so many barriers to it that it just wouldn't get  
9 done. So it was very problematic.

10 Q. Other than Optum and United, are there other PBMs  
11 that require the mail order?

12 A. Well, increasingly, what we have been seeing is a  
13 lack of -- well, what we're seeing is that they're taking  
14 away -- pharmacy choices being taken away from patients, and  
15 they're being told that they have to use a particular  
16 pharmacy or they have to use a particular mail order program.  
17 Most of our -- sometimes there is a bit of a financial  
18 benefit to patients if they use mail order. Now, some places  
19 they'll get three months' worth of medication but only pay  
20 two months' worth of co-pays. But almost a hundred percent  
21 of our patients were more than willing to pay the additional  
22 co-pay in order to stay with our pharmacy and that  
23 relationship.

24 Q. And are there instances where the mail order invades  
25 the privacy of the HIV patient?

1       A.       That was another problem that we encountered where  
2       medications were just left at a home where there might have  
3       been roommates or family members. We had situations where  
4       patients reported that the medications were -- because nobody  
5       was home that they were delivered to a neighbor and there was  
6       a note to pick it up from a neighbor. We had one very tragic  
7       situation in Florida where medication was delivered to a  
8       home. The family opened up the package, found out that their  
9       son was HIV-positive, and threw him out of the house.

10      Q.       Now, if you could explain a little bit more about  
11      this increasing concentration in the industry. Are there  
12      other effects?

13             You mentioned the night Optum/United example, which  
14      was a integration circumstances. But has the consolidation  
15      affected individual pharmacies like AHF and others?

16      A.       It definitely has. You know, these PBMs are -- they  
17      seem to increasingly be assessing higher what are called DIR  
18      fees, direct and indirect, remuneration fees, with very  
19      little transparency as to what were really being assessed.  
20      It's clawed back millions of dollars from us, and those are  
21      dollars that would normally be used to support our programs  
22      and our mission as a safety net provider. I mean 96 cents of  
23      every dollar generated in our pharmacy is poured right back  
24      into our clinical programs.

25             So, you know, we're seeing more and more of that to

1 the point that we're taking a big financial hit. And I'm not  
2 an expert on DIR fees, but I just -- some of them are  
3 assessed for what the PBM says are AHF not meeting certain  
4 quality metrics that, frankly, seem to be arbitrary and  
5 capricious. Like, we've had money taken back because certain  
6 patients weren't on a Statin, a cholesterol-lowering  
7 medication. But there are times that you can't use Statins  
8 with HIV medications. There are going to be life-threatening  
9 drug interactions. The other thing is I just don't  
10 understand how you can hold the pharmacy responsible for  
11 something that they can't prescribe medications. That's the  
12 physician. Anyway, things like that that are very  
13 frustrating.

14 Q. So these fees are where the PBM is actually clawing  
15 back money that had already gone to the pharmacy later?

16 A. Yes. And I think with AHF it is into the millions.  
17 And the thing is that they can claw back way after the  
18 adjudication of the claim. They can come back like a year  
19 later and ask you for significant sums of money back.

20 Q. Have you also seen an effect on the reimbursement  
21 rates that you're getting from PBMs?

22 A. The other thing -- I mean, we certainly aren't alone  
23 in this -- but some of the -- the reimbursement rates have  
24 dropped, and at times to a point where it doesn't even cover  
25 the cost of our medication, of the medication that we

1 purchase. So, obviously, that's another big issue.

2 Q. And why can't AHF just decide to go to another PBM?  
3 What's --

4 A. So, if you take a plan like our managed Medicare  
5 plan, which, like I mentioned, is a special needs plan, it is  
6 especially designed for people with HIV, so it's way  
7 different from a regular Medicare Advantage plan in that  
8 sense. But we still are required by CMS, our managed care  
9 plans have to meet certain criteria. And one of them is  
10 access to pharmacies where patients can get their  
11 prescriptions filled that are within a certain distance and a  
12 certain time of travel from the patient. And we're a small  
13 network of pharmacies. So to have something that is  
14 convenient for our patients that meets CMS requirements, we  
15 need to be contracted with a large chain like CVS which has  
16 got locations everywhere.

17 Q. So, basically, you have no choice, is that what  
18 you're saying?

19 A. Yes.

20 Q. Okay. Can you talk about how PBMs have narrowed  
21 networks.

22 A. So the other thing that PBMs have done is that  
23 they've created what are called narrow networks of  
24 participating pharmacies so that they may have CVS in there  
25 but have hardly anybody else that is allowed to participate,

1       so excluding independent pharmacies from participating, from  
2       being preferred providers under the PBM.

3       Q.       And Dr. Sood, you heard his testimony, he talked  
4       about a lack of transparency in the PBM market.

5       A.       Yes.

6       Q.       Is that something that you have found?

7       A.       Yes.  Again, I'm not the pharmacy budget expert, but  
8       I will tell you from sitting on the pharmacy exec committee  
9       and so forth, I mean, one of the frustrations is that there  
10      is no transparency.  You don't know what deals the PBM has  
11      worked out for rebates, and you don't have any clear criteria  
12      about how they're assessing these DIR fees.  Yeah, it's like  
13      a black box that you can't see through.

14      Q.       And there has also been public discussion about how  
15      PBM contracts have, quote/unquote, gagged pharmacies.

16      A.       That has certainly been in the news where some of the  
17      PBM contracts contain essentially gag orders on their -- say  
18      you've got under your plan a co-pay for a medication that is  
19      \$10 but you're getting a very common generic, and you could  
20      get the entire -- you could just pay the cash price and get  
21      it for like \$2.  You know, pharmacists were prevented by  
22      several PBMs from informing the patient of that.  So, yeah,  
23      those -- and you know, in my experience, what the PBMs have  
24      done is they have really added a layer of bureaucracy,  
25      another layer between provider and patient.  And certainly,



1 from a care side, clinical care side or a patient side, I see  
2 zero benefit and only harm, to be honest.

3 Q. What was the promise of PBMs when they entered the  
4 market?

5 A. I think it was that they were going to reduce prices  
6 to patients, to consumers, was one of them. And again, I  
7 haven't seen that. I mean, in fact, I have seen -- I had one  
8 situation where the PBM moved all of the HIV medications to  
9 its highest co-pay tier, a tier of five, and then some of the  
10 plans were actually -- that were contracted with the PBM were  
11 actually setting the patient responsibility portion to  
12 50 percent of the retail cost of the medication. I had a  
13 patient who called me up in tears because he went to pick up  
14 his medication and suddenly they were telling him it was \$900  
15 a month, which was half the retail cost.

16 Q. Now, there has also been public discussion of what  
17 they call squeeze-and-buy strategies by PBMs. Can you tell  
18 the Court what that's about.

19 A. So my understanding is that PBMs either, you know,  
20 through DIR fees and/or lowered reimbursements, that they  
21 squeeze an independent pharmacy, smaller pharmacy chain to a  
22 point that it is no longer economically viable for them to  
23 continue to operate, and then they kind of buy them out at  
24 pennies on the dollar. There was just an article the other  
25 day I read about it with a pharmacy or pharmacy group called

1 Premier Specialty Pharmacy, I think, and they basically said  
2 in this article, we can no longer be viable with what's  
3 happened to our reimbursements.

4 Q. Who did Premier sell out to?

5 A. CVS.

6 Q. I want to talk about the effects of the merger.

7 So do you have any concerns? I mean, you said  
8 initially you were concerned about the merger and that's why  
9 you're here. Can you tell the Court what specifically your  
10 concerns are with respect to the merger as it is currently  
11 constituted?

12 A. You know, my concern is that AHF, our pharmacies will  
13 be squeezed the way these others have; that either they won't  
14 be preferred pharmacies for patients under their insurance or  
15 they'll be excluded completely from using the AHF pharmacy.  
16 I'm concerned that it really cuts into these decreases in  
17 reimbursement and this clawback of fees.

18 THE COURT: Doctor, let me ask you a question about  
19 that.

20 THE WITNESS: Sure.

21 THE COURT: Who is it that sets these kinds of  
22 requirements? Is it the insurance plan or the PBM that's  
23 requiring --

24 THE WITNESS: So --

25 THE COURT: First of all, defining something as the

1 preferred source of the drugs.

2 THE WITNESS: Uh-huh.

3 THE COURT: And secondly, where they can get the  
4 drugs other than your pharmacy.

5 THE WITNESS: Right. And I believe that -- if I'm  
6 wrong, please somebody correct me -- but I believe that  
7 really is set by the PBM, to a large extent. I guess by  
8 the -- I'm not exactly -- what role the insurer has, but I  
9 believe it is mostly the PBMs that set up the networks of  
10 participating pharmacies and so forth, and make these  
11 decisions about co-pays and what patients are going to have  
12 to pay and where they can access their -- and how they can  
13 access their medications.

14 THE COURT: Say your pharmacies aren't designated as  
15 preferred providers, then they have to go to -- do they list  
16 who the preferred providers are?

17 THE WITNESS: Yes. I mean, they usually will. I  
18 mean, so it may not completely bar a patient from going to a  
19 nonpreferred provider, but there's lots of economic  
20 disincentives to do that.

21 THE COURT: So the co-pay will be a lot higher --

22 THE WITNESS: Exactly.

23 THE COURT: They'll charge much more for the drug --

24 THE WITNESS: Correct.

25 THE COURT: So you have seen that firsthand?

1 THE WITNESS: Yes.

2 You know, I think that a lot of people don't realize  
3 that there is, and should be, a relationship between -- in  
4 people with chronic illnesses, serious chronic illnesses --  
5 that there is, and should be, a relationship between the  
6 pharmacist and the patient. And I think we've demonstrated  
7 at AHF how important that relationship is.

8 I mean, very frequently I find out for the first time  
9 that a patient is having side effects or problems with  
10 medication, not from the patient telling me, but the patient  
11 has told the pharmacist, who then tells me. Then the  
12 pharmacist and I work together to resolve the problem.

13 And in a condition like HIV, the pharmacist is really  
14 important in educating the patient about the importance of  
15 adherence.

16 And one of the other things with PBMs is that when  
17 you call a PBM, you have no idea who you're going to speak  
18 to. There is no ongoing relationship. I've had situations  
19 where I've spoken to a pharmacist, and they can't even  
20 pronounce the names of the drugs I'm talking about. They  
21 have no experience with HIV medications. And it is very much  
22 kind of a -- it is like calling customer service a lot of  
23 places, and you get caught in voice mail hell.

24 THE COURT: Okay.

25 BY MR. BARLOW:

1 Q. Is it your concern that the merger will affect how  
2 Aetna's patient population will be directed to certain  
3 pharmacies?

4 A. Well, I mean, I would think that is likely to happen  
5 and certainly is a concern. Anything that is going to pull  
6 patients out of our pharmacy, where they've got specially  
7 educated pharmacists and staff, they've got a very close  
8 personal relationship, it's -- we have -- in every one of our  
9 clinics we start the day with what is called a morning huddle  
10 where we discuss all of the patients coming in that day. And  
11 the pharmacist is part of that morning huddle. I mean that's  
12 how integrated they are into our care model.

13 Q. And so what happens if all of the Aetna patients are  
14 directed to CVS pharmacies and away from specialty providers  
15 like AHF? What is the practical effect of that?

16 A. So, you know, I think that you're going to see more  
17 patients getting sick, frankly. I mean, again, you can't  
18 walk out of a CVS if you don't have your co-pay. And we  
19 especially seek out -- seek to place clinics in places where  
20 patients don't have great access to care, where they're  
21 economically disadvantaged, and so forth. But we make sure  
22 that they always get their meds; that if there's a co-pay, it  
23 is always the lowest tier co-pay; that they've got access all  
24 the time to pharmacists for education.

25 I also know that CVS isn't going to have a 35-day

1 report and call patients to ask why they haven't been in to  
2 pick up their medications.

3 The other thing that I might mention is that  
4 increasingly insurers are requiring what are called prior  
5 authorizations for medications. So, in other words, before  
6 they will cover a medication, you have to do a prior  
7 authorization, which often involves doing this whole medical  
8 justification. And you'll find doctors nowadays who really  
9 are -- you know, take the attitude this isn't really my  
10 problem. You know, I ordered the medication. This is what I  
11 thought you needed. Take it up with your insurance company  
12 if they don't want to pay it.

13 But what we do at AHF, and really headed by the  
14 pharmacist, is that we aggressively work to get that prior  
15 authorization approved. So we act as an advocate for the  
16 patient, as well.

17 Q. Is there also a concern of the merger that Aetna  
18 patients going to MinuteClinics? Is that something that  
19 you're concerned about?

20 A. You know, I have read that part of this integrated  
21 care concept with this merger is that now you've got all of  
22 these clinics around the company that are now going to be  
23 part of the patient's care network. Look, I think a  
24 MinuteClinic is fine if you need a particular vaccine or if  
25 you have got a cold or something like that. I think it would

1 be a disaster if HIV patients were encouraged to seek medical  
2 care at a MinuteClinic. I can, again, tell you that HIV is a  
3 highly specialized -- I think this is true for any chronic  
4 illness. I don't know that HIV is unique in this sense. But  
5 you know, what you're going to get is fragmented care by  
6 people who don't understand the disease and who don't  
7 understand the risks of drug interactions, adherence, side  
8 effects, all that kind of stuff.

9 Q. Let's take as an example a flu shot?

10 A. I'm sorry?

11 Q. A flu shot.

12 What is the effect of an HIV/AIDS patient getting a  
13 flu shot at a MinuteClinic?

14 A. There are certain types of flu shots that HIV  
15 patients are not supposed to receive because of weakened  
16 immune system. There are certain types of -- as a general  
17 rule, live-virus vaccines are usually not given to HIV  
18 patients because their weaknesses in their immune system  
19 could create particular side effects. We are very aware of  
20 those kinds of issues. I highly doubt that a MinuteClinic is  
21 -- you know, they probably have whatever flu shot they're  
22 giving, and I kind of doubt that they would be aware that  
23 there are certain types that should not be given to patients  
24 with HIV.

25 Q. In terms of privacy, you spoke about that earlier,

1 are you aware of instances where both CVS and Aetna have been  
2 sued for violating privacy of HIV patients?

3 A. I know they have both been sued over separate  
4 instances of revealing patients' HIV status.

5 Q. Now, you heard Dr. Sood testify about what he called  
6 about input foreclosure. Do you remember his testimony  
7 there?

8 A. Yes.

9 Q. The idea being that there's a risk after the merger  
10 that there will be a degradation of care, so to speak, from  
11 the pharmacy, or the PBM level down to the health plan level.  
12 Is that something you're concerned about?

13 A. Yes. I mean, for all the reasons I have already  
14 mentioned, it is a very different setup than what our  
15 pharmacies have.

16 Q. Well, for instance, what if one of your managed care  
17 plan patients was forced out of that plan into say an Aetna  
18 Medicare Advantage plan? What would be the effect of that?

19 A. Well, first, the biggest impact is that these  
20 Medicare Advantage plans are not special needs plans. By  
21 virtue of the fact that we have a designation that our plans  
22 are designated as SNPs or special need plans, you know,  
23 patients actually are not limited to the enrollment period  
24 with Medicaid Advantage. They can come on and off our plan  
25 as needed. Our co-pays for HIV medications are set at the



1 lowest-tier co-pay. There's -- they go from -- they could be  
2 assigned to a PCP who was just most likely a general  
3 internist or family practitioner who probably knows little to  
4 nothing about HIV treatment. A lot of concerns.

5 Q. And that could happen if post-merger the CVS pharmacy  
6 services were denied to a health plan participant?

7 A. Yes. I mean, I don't know that under CMS rules that  
8 we can meet CMS -- our plans can meet CMS rules if we aren't  
9 contracted with somebody like a CVS.

10 THE COURT: Can you give me some idea, Doctor, of one  
11 of your chronic patients who has HIV and is on this regimen  
12 of multiple medications --

13 THE WITNESS: Yes.

14 THE COURT: -- what would the monthly charge for  
15 medication be to him in terms of his co-pay and in terms of  
16 the insurer --

17 THE WITNESS: Right.

18 THE COURT: -- the retail amount --

19 THE WITNESS: So I would say that --

20 THE COURT: -- roughly.

21 THE WITNESS: -- a regimen would run somewhere  
22 between \$1,500 and \$3,000 a month in terms of the cost of the  
23 medication.

24 THE COURT: That is retail? Or wholesale?

25 THE WITNESS: That's what -- if a patient came in and

1       needed to buy it cash, that's what they would pay.

2               THE COURT:   Okay.

3               THE WITNESS:   And the co-pays vary a lot based on the  
4       patient's plan.   But I'm pretty certain that all insurance  
5       companies, other than AHF, have HIV medications on the  
6       higher-tier co-pays, which mean higher out-of-pocket cost.  
7       In fact, with that patient I mentioned who suddenly -- he  
8       went up to a tier where he was responsible for 50 percent of  
9       the retail cost of the medication, you know, I had  
10      conversations with the PBM, and they were very surprisingly  
11      honest with me and said:   We want to put these meds on a  
12      higher tier because we don't want anything that is going to  
13      actually encourage HIV patients to choose our plan.   We don't  
14      want to make it appealing to them because they're high-cost  
15      patients.

16              THE COURT:   So what would the lowest co-pay be, how  
17      much a month, roughly?   500?

18              THE WITNESS:   No, it probably is less -- again -- so  
19      you've got some patients who are on plans that they have a  
20      set co-pay amount.   So it could be \$50 or \$75 or something  
21      like that.   This was a particularly unusual setup, yeah,  
22      yeah.

23              THE COURT:   You've got about five minutes left.

24              MR. BARLOW:   Okay.

25              BY MR. BARLOW:

1 Q. Just to wrap up, you've heard the benefits of the  
2 merger that have been put forth by the parties. One of them  
3 that's been talked about is that the merger will lead to  
4 increased compliance with treatment plans, medication therapy  
5 management.

6 Do you have any reaction to that claim?

7 A. I don't see that. I honestly can't even conceive of  
8 how that would be improved. It just seems that there would  
9 be fragmentation of care.

10 Q. Have you reviewed the DOJ's proposed Final Judgment?

11 A. I did read it, yes.

12 Q. In your view, is the approval of the proposed Final  
13 Judgment in the public's interest?

14 A. Personally, I don't think so because it doesn't  
15 address these particular issues. And I'm afraid that without  
16 addressing them that we will end up with a very uneven,  
17 unfair playing field that will make it hard for AHF to  
18 compete. I think that, you know, given a level playing  
19 field, I think that we can compete, because based on our care  
20 model and our personal service, and you know, I think  
21 patients choose to stay with us, to use our plan, but I'm  
22 worried that that won't be enough because it won't be an even  
23 playing field.

24 Q. Would there be an alternative to approval of the  
25 judgment that in your judgment would alleviate your concerns?

1       A.       It would be great to see if there were guarantees of,  
2       you know, pharmacy choice and that patients and -- and also  
3       that our plans would continue to be able to participate as  
4       preferred providers in the -- like, in the CVS pharmacy  
5       network. But I would feel a lot more comfortable if there  
6       were language that did that.

7               MR. BARLOW: That's all I have, Your Honor.

8               Thank you.

9               THE COURT: Let me ask one last question. The  
10       insurance programs that you offer as part of your services --

11              THE WITNESS: Yes.

12              THE COURT: -- those, like your institute itself, is  
13       a not-for-profit; is that correct?

14              THE WITNESS: That is correct.

15              THE COURT: So the profit incentive or motive that  
16       other companies that offer insurance programs --

17              THE WITNESS: Right.

18              THE COURT: -- is not present in yours?

19              THE WITNESS: That's correct. Yeah.

20              THE COURT: Very good.

21              Thank you, Doctor. You can step down.

22              THE WITNESS: You're welcome.

23              THE COURT: We will take a 15-minute recess, and then  
24       we'll hear the final witness for today when we return.

25              So we stand in recess.

1 (Recess taken)

2 THE COURT: Call your witness.

3 MR. BALTO: Your Honor, David Balto on behalf of  
4 Consumer Action United States Public Interest Research Group,  
5 we call Dr. Diana Moss as a witness.

6 THE COURT: All right. Come up and be sworn.

7 DIANA L. MOSS,

8 having been duly sworn, was examined and testified as  
9 follows:

10 DIRECT EXAMINATION

11 BY MR. BALTO:

12 Q. Dr. Moss, please state your name and spell it for the  
13 Court.

14 A. My name is Diana L. Moss, D-I-A-N-A, L, M-O-S-S.

15 Q. Diana Moss, can you please give the Court an overview  
16 of your testimony for today.

17 A. Yes. My testimony today will cover two basic themes.  
18 One is comments and observations on the horizontal aspects of  
19 this proposed merger between CVS and Aetna and the  
20 consolidation in the standalone PDP markets and the proposed  
21 remedy and whether we think that remedy will likely be  
22 effective in preserving competition. And then the second  
23 part of my comments will address very serious competitive  
24 concerns that were not addressed by the government, and that  
25 includes two forms of vertical foreclosure and their effects

1 on competition and consumers.

2 Q. Dr. Moss, can you please introduce yourself to the  
3 Judge and give him a bit of your biographical background,  
4 including on merger divestitures.

5 A. Certainly. I am the president of the American  
6 Antitrust Institute. We have been around for about 20 years,  
7 a progressive think tank advocating for competition that  
8 protects consumers and businesses in society. We do that  
9 through legal, economic, and policy work in the form of  
10 research, education, and advocacy.

11 I am a Ph.D. economist, and have worked in the area  
12 of industrial organization for almost all of my career in a  
13 number of sectors, including healthcare.

14 AAI has been very active in the healthcare area. We  
15 have filed a number of letters to the agencies, the FTC, DOJ,  
16 the states, white papers, letters. We have testified in  
17 front of Congress, in front of various commissions on the  
18 competitive and consumer effects of healthcare consolidation.

19 Most recently, I have turned my research to remedies  
20 in merger cases and have co-published an article with John  
21 Kwoka -- Professor Kwoka is at Northeastern University -- on  
22 issues and problems that we have identified with different  
23 types of merger remedies, including conduct remedies versus  
24 structural remedies, and recently had a piece out in *Global*  
25 *Competition Review* in their *Guide to Merger Remedies*.

1 Q. Thank you.

2 By the way, you have been a public servant in the  
3 past; isn't that correct?

4 A. I have been a public servant. I was at the Federal  
5 Energy Regulatory Commission for about six years, where I  
6 coordinated the Commission staff work on electricity mergers.

7 Q. Dr. Moss, please tell the Judge about AAI's  
8 healthcare competition expertise.

9 A. So, as I said just a minute ago, we have a diverse  
10 array of resources through our advisory boards, through our  
11 staff expertise, with expertise in law, economics,  
12 institutional issues, and public policy. And much of that  
13 has focused on a variety of industries, including healthcare,  
14 where we have been very active in promoting competition and  
15 vigorous review by the federal and the state -- federal  
16 agencies and the states to look at these mergers in  
17 healthcare at all levels of the supply chain because we have  
18 really grave concerns about their effects on competition and  
19 on consumers and workers.

20 Q. What is the specific advocacy that AAI did on  
21 CVS-Aetna?

22 A. So we submitted a letter back in March of 2018 to the  
23 U.S. Department of Justice, Antitrust Division, unpacking the  
24 vertical aspects of the CVS-Aetna merger. We also filed  
25 Tunney Acts in December of 2018 in this Tunney Act

1 proceeding.

2 Q. Can you give the Judge a brief picture of the kind of  
3 healthcare advocacy AAI does; studies, reports, things like  
4 that?

5 A. So our analyses are fairly deep dives into legal,  
6 economic, policy, and institutional analysis. We take weeks,  
7 if not months, to produce a white paper, which is typically a  
8 heftier, beefier analysis. And we do that on a regular  
9 basis. We choose our cases very carefully, cases that we  
10 believe raise really seminal issues of law or policy or  
11 economics.

12 And I'm not shy about saying that I think that AAI's  
13 work is generally regarded as independent and objective and  
14 very high quality.

15 Q. Dr. Moss, have courts relied on AAI's advocacy in the  
16 past?

17 A. I believe that to be true. And we have been cited by  
18 courts in a number of areas, including our amicus briefs, our  
19 white papers, and letters in a variety of cases. Most  
20 recently cited or referred to as a titan in the antitrust  
21 arena, something that we were very gratified to hear.

22 Q. Thank you.

23 Dr. Moss, given your expertise in antitrust and  
24 healthcare, what are the important lessons for the Court  
25 today from what you have heard from Dr. Sood and



1 Dr. Wohlfeiler's testimony?

2 A. So I think there are three major takeaways or  
3 observations so far that I would like to offer to the Court  
4 about this particular merger and consolidation in healthcare  
5 more generally.

6 I would like to emphasize that we are really at an  
7 inflection point in consolidation in the healthcare  
8 industries. There has been sweeping and massive  
9 consolidation in all levels of the healthcare supply chain;  
10 in hospitals, in pharmacy benefit manager markets, in retail  
11 pharmacy markets, in health insurance. What we have moved  
12 from is pretty vigorous competition by standalone rivals at  
13 each level in the supply chain. We have moved from that  
14 model of well-ventilated, competitive markets where rivalry  
15 produces the low prices and the high quality and innovation  
16 for consumers. We've moved from that to a system where we  
17 now have vertically integrated platforms of insurers and  
18 pharmacy benefit managers and pharmacies. For example,  
19 Express Scripts-Cigna just went through. We have  
20 UnitedHealthcare and Optimum as a vertically integrated  
21 insurer and PBM. We now have CVS-Aetna on the table as yet  
22 another vertically integrated entity. I have seen mention in  
23 the press of Centene and WellCare merging in another vertical  
24 combination.

25 So what this does is it fundamentally changes the

1 structure of the industry, and it changes the incentives and  
2 the abilities of these firms to compete hard on price and  
3 quality, because through vertical integration, they have  
4 incentives, much of which we have heard about today from  
5 Dr. Sood, incentives to foreclose their rivals or to make it  
6 difficult for their rivals to compete. So having a bunch of  
7 vertically integrated firms -- and it is not even a bunch, it  
8 is just going to be a few when this is all over --  
9 unfortunately have very conflicted incentives to promote  
10 competition, to serve and deal with their rivals at arm's  
11 length, and that raises serious issues for consumers and  
12 competition.

13 The second point I would like to make is that this is  
14 really a very high-stakes game. Not only are consumers  
15 implicated by the CVS-Aetna merger, but taxpayers are  
16 implicated through the Medicare Part D and low-income subsidy  
17 program. We have high-risk individuals, as we just heard  
18 from the previous witness, who are potentially in danger.  
19 And these are important parts of consumers' pocketbooks.  
20 Insurance premiums are an enormous part of a pocketbook or  
21 family spending. Drugs costs are an enormous part of  
22 spending for healthcare providers. And I believe drug costs  
23 are approaching about 20 percent of total healthcare  
24 expenses.

25 We also have a quality issues. This is not just

1 about price and higher premiums and higher drug prices and  
2 costs, but it is about quality. It is about disease  
3 prevention. It is about keeping mortality rates down. It is  
4 about innovation, innovating new technologies, new drugs, new  
5 business models to serve competition and consumers.

6 So I just want to emphasize the price and the  
7 non-price dimensions.

8 Finally, the third point or takeaway, and Dr. Sood  
9 spoke to this really terrifically well, is high concentration  
10 in markets should be given a significant amount of weight.  
11 And it is a strong -- creates a strong presumption of  
12 illegality under Section 7, which is an incipency doctrine,  
13 as we know. And the reason why concentration is so important  
14 here is in regard to consolidation in these PDP markets and  
15 the requirements that creates for a very effective remedy to  
16 ameliorate those concerns.

17 But when we turn to the vertical issues, it is also  
18 extremely important to realize that high concentration in PBM  
19 and pharmacy markets and also in health insurer markets  
20 really limits choices for consumers to switch away from a  
21 company that might be engaging in anticompetitive conduct.

22 So we don't need a lot of rocket science and  
23 bargaining theory. This is pretty simple stuff. When you  
24 have markets that only contain two or three dominant firms,  
25 rivals, that really limits the ability for consumers to

1 switch, or any other participant in the market to switch away  
2 from a firm that is vertically integrating or horizontally  
3 integrating.

4 Q. Dr. Moss, let's spend a moment on that difficulty of  
5 switching. So let's say that tomorrow there is a new policy  
6 suggested, like Dr. Wohlfeiler suggested. Why can't a  
7 consumer just sort of pick things up and move from one  
8 insurance plan to another plan?

9 A. Well, the most obvious reason is because they're  
10 aren't many options. Right? If you can't deal with CVS,  
11 which is essentially a "must have" pharmacy network for many  
12 insurers and there are very few options to turn to, then that  
13 limits the opportunities.

14 Secondly, there is in many cases brand name loyalty  
15 that creates a lock-in effect for some consumers, health  
16 insurers, for example, in preventing switching. But,  
17 fundamentally, when you have very few rivals in a market,  
18 economic theory and evidence shows that higher levels of  
19 concentration contribute to either following behavior by  
20 firms or coordination between firms, which results in higher  
21 prices and lower quality.

22 So consumers are really disadvantaged by tight  
23 oligopoly markets where you just have a few rivals.

24 Q. Dr. Moss, let's focus on the PDP market. Why is  
25 concentration so crucial in this market?

1       A.       So in the PDP market, I would note that the  
2       government, in its complaint -- I'm sorry -- the competitive  
3       impact statement actually led with the statement that  
4       competition is critically important in these PDP markets.  
5       They say Congress designed the Medicare Part D program to  
6       rely on competition --

7               THE COURT:   Slow down.

8               THE WITNESS:  -- among multiple plan sponsors.

9               Sorry.

10              PDPs are really, really increasingly important to  
11      consumers.  There's been 6 percent year-over-year growth in  
12      Medicare Part D enrollments from 2006 to the present.

13      There's been an 18 to 30 percent growth in Medicare's share  
14      of U.S. retail prescription drugs spent between about the  
15      same period of time.  So the Medicare Part D PDP plans are  
16      increasingly important to consumers, particularly seniors,  
17      low-income consumers, at risk-types of market participants.

18              We're concerned that average monthly premiums have  
19      escalated rapidly, especially since 2015.  There's been an  
20      11 percent increase in premiums for standalone PPDs, and a 53  
21      percent increase in premiums for low-income-subsidy  
22      enrollees.  Those are really, really significant increases in  
23      premiums for populations, consumer populations, that are at  
24      risk.

25              The other reason why concentration is so critically

1 important is because when you have a market that is dominated  
2 by entrenched large firms and a very small fringe of tiny  
3 firms, much like we see in the PDP markets, then it is really  
4 hard for those smaller firms to inject any competitive  
5 discipline in the market. They need access to financial  
6 resources. They have to engage in multi-year planning. They  
7 need scale. They need personnel. They have to contract with  
8 pharmacies and other providers.

9 So, unfortunately, with highly concentrated markets,  
10 as we see in insurance and in pharmacy and PBMs, we just  
11 don't have smaller firms that have the heft and the ability  
12 to inject competitive discipline.

13 Q. What are the obstacles for those smaller firms to  
14 effectively expand in the PDP market?

15 A. I think they're very limited. And we have seen  
16 failures of smaller firms to be able to enter. In the case  
17 of the CVS-Aetna merger and the Express Scripts-Cigna merger,  
18 where we are seeing more and more vertically integrated  
19 platforms, that will raise entry barriers significantly  
20 because firms can't enter at just one level anymore. So a  
21 firm can't have an innovative online pharmacy model and  
22 really effectively enter without having integration into a  
23 base of insurance customers, for example.

24 So all of this consolidation in the industry,  
25 including this merger, has really raised barriers to entry

1 for smaller market participants.

2 Q. Do those factors lead to further consolidation? Do  
3 they in effect force firms to consolidate recognizing that  
4 they can't expand?

5 A. Yes. I think that firms in a market where you have  
6 just a few entrenched dominant firms and a very small fringe  
7 of struggling rivals, I think it creates a scenario where  
8 small firms are more easily picked off by the larger firms,  
9 which creates yet another wave or another cycle of  
10 consolidation.

11 Q. Let's talk about how highly concentrated the market  
12 is if this acquisition is consummated.

13 A. So we're talking about PDPs, PDP markets. So  
14 Dr. Sood I think has done a really terrific job of  
15 highlighting the high levels of market concentration in  
16 multiple regions under the PDP plans.

17 I believe the DOJ's complaint states that 12 Part D  
18 regions, which is about 75 percent of the relevant geographic  
19 markets, will result in large increases in concentration.  
20 CVS-Aetna would account for more than 35 percent of the  
21 low-income-subsidy-eligible beneficiaries in an additional  
22 nine regions.

23 So, clearly, the merger results in anti- -- will  
24 likely result in anti-competitive effects and anti-consumer  
25 effects in these PDP markets, and is really presumed to

1 enhance the market power. So that's where this strong  
2 presumption of illegality or the structural presumption of  
3 illegality comes in here.

4 Q. Let's spend a few minutes, Dr. Moss, talking about  
5 whether the effects from increased concentration or other  
6 forms of anti-competitive harm. We've talked a bit about  
7 price. I presume the witnesses tomorrow will say there is no  
8 price effect.

9 What is your response to that?

10 A. Well, I think all of the empirical evidence that  
11 Dr. Soot has cited and that I have certainly seen is that  
12 premiums will increase as a result of consolidation. And  
13 quality may well go down as a result. There may be -- there  
14 may be a degradation in coverage. There may be a degradation  
15 in terms of the drugs that are offered in the plans. There  
16 may be fewer incentives, for example, to protect consumers',  
17 subscribers' privacy. That is a sort of a quality  
18 competition issue. And certainly much less pressure to  
19 innovate in terms of providing better service, new products,  
20 faster to market.

21 So I think both the price and the non-price effects  
22 from a highly concentrated merger like this in the PDP  
23 markets is really a very serious concern.

24 THE COURT: The non-price effects include  
25 availability of drugs, more readily available?



1 THE WITNESS: Absolutely, yes.

2 THE COURT: So putting price aside, which is  
3 obviously one barometer of evaluating whether it is in the  
4 public interest or not --

5 THE WITNESS: Yes.

6 THE COURT: -- availability or lack of availability  
7 to drugs --

8 THE WITNESS: Right.

9 THE COURT: -- what would be probably next most  
10 important after that in the non-price?

11 THE WITNESS: From a non-price effect?

12 So availability of the drugs. Is the coverage in  
13 terms of the portfolio or the formulary appropriate for the  
14 subscribers? Are there drugs that are in demand? I think  
15 there are fewer incentives with less competition to innovate  
16 on newer, better business models or delivery systems for  
17 drugs to really bear down on efficient contracting practices  
18 with drug companies and other members of the supply chain.

19 So the non-quality aspects of competition I think are  
20 really, really as critical as the price effects of  
21 competition.

22 BY MR. BALTO:

23 Q. Let's go back -- just to fully inform the Court,  
24 let's go back to Dr. Wohlfeiler's testimony and recall what  
25 he testified about, about the relationship between the

1 pharmacist and the patient, the advice that they receive, or  
2 the concerns about privacy.

3 Are those kinds of concerns cognizable? Are those  
4 the kinds of concerns that the Court should look at?

5 A. I believe the Court should legitimately look at those  
6 concerns.

7 What we have found through research is a record of,  
8 for example, independent pharmacies having a much harder time  
9 competing as a result of practices by PBMs in a highly  
10 concentrated market. And consumers have lost, for example,  
11 access to independent pharmacies that offer counseling  
12 services for risk of heart disease and diabetes. And those  
13 types of services may well disappear as a result of the  
14 integration that we're seeing here.

15 Q. So something like AHF's offering drugs no matter what  
16 the coverage is or providing the 35-day call, the loss of  
17 services like those would be cognizable?

18 A. Absolutely.

19 Q. Okay. Well, we're here today to talk about whether  
20 or not this is an effective merger remedy.

21 Dr. Moss, first of all, give the Judge your  
22 perspective generally, looking at hundreds of merger  
23 remedies, about what it is the agencies and courts are  
24 supposed to do and whether or not that effectively works.

25 A. The agency's own guidelines state that a merger

1 remedy should fully restore competition lost by the merger.  
2 Another way of saying that is that the remedy must preserve  
3 competition, essentially as if the merger had never occurred.

4 So that's what an effective remedy essentially is, is  
5 one that fully restores competition lost by the merger. An  
6 effective remedy should really align with a magnitude of  
7 competitive and consumer harm. Right? So the more serious  
8 the concern, as we see here in the PDP markets with the  
9 effect of this merger, really is a heavy lift on crafting a  
10 remedy that is going to fully restore competition.

11 And I would note for the record that sometimes the  
12 most effective remedy is for the government to move to block  
13 the merger, in fact. And we have seen that. We saw that in  
14 previous insurance mergers, in Anthem-Cigna and also in  
15 Aetna-Humana where both mergers were essentially denied  
16 because they were concentrative and would have created  
17 significant harms.

18 In AIA's 20 years of research and advocacy, we have  
19 seen a growing list of a number of failed remedies. And this  
20 remedy, the PDP remedy here, concerns us because it bears a  
21 lot of resemblance to some of these other cases. For  
22 example, in the healthcare space, UnitedHealth and Sierra  
23 merged, Aetna and Prudential merged, and Humana and Arcadian  
24 merged. These all occurred within the last, say, 10 or 15  
25 years.

1           So in the first two of those cases,  
2           UnitedHealth-Sierra, Aetna-Prudential, after a divestiture,  
3           it was documented empirically that rates went up, that  
4           premiums went up. So that would not be an effective remedy  
5           if the divestiture were put into place and then prices went  
6           up afterward.

7           In Humana-Arcadian, WellCare had assumed those assets  
8           in several counties in Arizona and then two years later  
9           exited the market. That would not be an effective  
10          divestiture because the buyer was unable to maintain or  
11          reinject competition.

12          We have seen failed remedies in Safeway-Albertsons,  
13          in Dollar Tree-Family Dollar, in Hertz-Dollar-Thrifty, all  
14          buyers who were unable to maintain the assets who could not  
15          step into the shoes of the merging party that divested the  
16          assets. So all of this means that a remedy was ineffective  
17          and that the harmful effects of the merger actually did occur  
18          because the remedy was not successful. And we have very  
19          similar concerns in this case.

20          Q.          So the last time WellCare had a divestiture, it  
21          struck out?

22          A.          In the Humana-Arcadian merger, that is correct.

23          Q.          Is part of what the agencies -- how do the incentives  
24          and abilities of the firm that is acquiring the assets, how  
25          is that included in the analysis?

1       A.       So to fully restore competition or step right into  
2       the shoes of the market participant from which the assets are  
3       being purchased really requires a lot of things to fall into  
4       place pretty quickly and successfully.

5               So there are really three major observations about  
6       why that is likely not to be the case in CVS-Aetna in PDP  
7       markets.

8               One is simply the highly concentrated nature of the  
9       PDP market. And we heard this, of course, from Dr. Sood.  
10      But the punch line up front is that because of high  
11      concentration and just having a few firms in this market,  
12      United and Humana and CVS, I believe Express Scripts is in  
13      there a little bit, WellCare post-divestiture would have a 13  
14      percent market share, but because they're aren't any smaller  
15      firms and because WellCare was really on the fringe of even  
16      being a good candidate, you really don't have many  
17      possibilities as buyers of divested assets to reinject that  
18      competition.

19      Q.       So you're saying this is basically a very tough  
20      market to enter into even if you're given that boost of the  
21      additional Aetna lives?

22      A.       Absolutely.

23               And so there are several concerns as a second point  
24      about WellCare Health not being well positioned to  
25      successfully compete after it assumes the assets. It is much

1 smaller relative to Aetna. It is about a quarter of the size  
2 in terms of enrollees. It lacks the economies of scale and  
3 scope and the brand reputation that Aetna has. We've talked  
4 about that.

5 Also of concern is the fact that when WellCare Health  
6 assumes Aetna's PDP enrollees, they will need to absorb about  
7 180 percent increase in enrollees in a really short period of  
8 time. That's an enormous uptick in the number of enrollees.

9 We also know that WellCare Health has struggled a bit  
10 between 2014 and 2017. They lost on average annually about  
11 4.6 percent of their enrollees in these PDP plans that they  
12 have.

13 And as I just mentioned, they exited the market very  
14 shortly after buying assets in the Humana-Arcadian merger.

15 Q. In determining whether a firm has the ability to  
16 effectively restore competition, which you said earlier is  
17 fully restore competition, how crucial are these elements,  
18 the past history and the perspective of how much it has  
19 to --

20 A. Oh, I think they absolutely bear serious  
21 consideration in determining whether WellCare Health is a  
22 viable buyer of the assets and whether they are going to be  
23 able to reinject the competition.

24 To be honest, the way the consent -- the remedy is  
25 structured in the consent decree raises additional concerns.

1 It is a very limited set of assets. It is sort of riding on  
2 the border of being a divestiture of an ongoing business  
3 versus just a bundle of selected assets, which the FTC has  
4 had a lot to say about in examining its own divestitures.  
5 Brand loyalty could well limit WellCare's ability to attract  
6 customers later on. It puts enormous pressure on WellCare  
7 Health to quickly step in. The administrative services  
8 agreement that's part of the remedy expires at the end of  
9 this year. And Aetna can start re-marketing products under  
10 its own brand name and the CVS brand name in less than two  
11 years. Okay?

12 Aetna employees are not being transferred with the  
13 contracts, the PDP contracts.

14 So if you take all of these factors together, you  
15 have a track record and you have a remedy and you have a  
16 market, and critical attributes of the market in terms of  
17 high concentration that really call into question the  
18 efficacy of this remedy in addressing the very serious harms  
19 that are identified in the complaint.

20 Q. Dr. Moss, let's spend a little time unpacking some of  
21 this for the Court.

22 The administrative services agreement expires in  
23 2019. Why is that important to WellCare in being able to  
24 effectively enter the market and fully restore competition?

25 A. So, in many divestitures, there will be the actual

1       divestiture of the asset itself, although in this case this  
2       isn't a manufacturing facility. It is a collection of  
3       contracts. But other things need to go with it. There needs  
4       to be support. There needs to be transfer of information and  
5       records. There needs to be ability for the buyer to tap into  
6       the expertise and the advice of the original owner of the  
7       assets. So this collection of support in terms of access to  
8       the contracts and ability to use the brand name of Aetna for  
9       a year -- I believe it's a year -- those are all sort of  
10      ancillary but vitally important to supporting the actual  
11      divestiture of the assets itself.

12               And that, as I said, is only in place for about seven  
13      more months.

14               So WellCare will have to really hit the ground  
15      running fast and scale up fast and assume an enormous inflow  
16      of enrollees to be able to reinject this competition.

17               THE COURT: Do you have any idea what percentage of  
18      CVS's business is devoted to the PDP program?

19               THE WITNESS: You mean in terms of their overall, for  
20      example, overall revenues?

21               Your Honor, I do not have that number.

22               THE COURT: Do you know, would it be lesser or  
23      greater than the other non-PDP services that it provides?

24               THE WITNESS: In terms of CVS's business?

25               THE COURT: Uh-huh.



1 THE WITNESS: I could guess, but I'm reluctant to  
2 guess.

3 THE COURT: I don't want you to guess.

4 What, if any, significance do you view the  
5 apparent -- I think, if I understood Dr. Sood earlier today,  
6 the apparent strengthening of CVS's PBM services ability as a  
7 result of this merger as it relates to its other businesses?

8 THE WITNESS: Sure, sure. So CVS can continue  
9 to -- can continue to aggressively expand its PDP plans.  
10 Aetna can essentially reenter the market after a relatively  
11 short period of time. I think are big incentives, strong  
12 incentives for them to continue to do that.

13 If you take those parameters that have been crafted  
14 around the remedy in the consent order and you superimpose  
15 that dynamic onto the vertical integration that we see by  
16 pairing up a retail pharmacy and PBM with a health insurer, I  
17 think you have a rather toxic set of incentives or changed  
18 incentives and abilities to potentially make it difficult for  
19 rival health insurers to compete or rival pharmacies to  
20 compete.

21 So I think the combination of the horizontal  
22 integration in the PDP market and the ineffectiveness of the  
23 remedy and the vertical integration will significantly change  
24 incentives in ways that may be hard to predict but almost  
25 certainly will be harmful to competition and to consumers.

1           And I don't mean hard to predict in that we can't  
2       talk about what they are likely to be, but hard to predict in  
3       the sense that you're now dealing with a very complex, even  
4       more complex integrated business ecosystem where CVS and  
5       Aetna, with their affiliates in multiple businesses, will be  
6       leveraging across all of those different businesses in the  
7       post-merger, post-divestiture world.

8           BY MR. BALTO:

9       Q.       In other words, CVS having control of a PBM and  
10      control of "must have" retail pharmacies can use that  
11      leverage to forestall competition in other areas?

12      A.       Right. Yes, I think it goes without saying that the  
13      CVS brand and retail pharmacy and certainly PBM is viewed by  
14      rival insurers as being a "must have" input. A much, much  
15      stronger case than I think the case in the last big vertical  
16      merger, AT&T-Time Warner --

17           THE COURT: We heard about "must have" TV in that  
18      one. It didn't turn out to be as "must have" as some people  
19      thought.

20           THE WITNESS: I agree with you.

21           I would argue in this case this is a much stronger  
22      case for why input foreclosure could be very damaging and why  
23      these CVS pharmacy networks really are essential for rivals  
24      to compete.

25           BY MR. BALTO:

1 Q. Let's go back to drugs. So the point about brands,  
2 why is brand really important and the fact that they only  
3 have the brand for a short period of time and that CVS can  
4 reuse the Aetna brand --

5 A. Well, a lot of economic research has been done on the  
6 role of brand loyalty in shaping demand, controlling demand,  
7 if you will. We know that brand loyalty creates what we call  
8 lock-in effects where it really limits consumers' willingness  
9 to switch to rivals, rival providers. I think in the  
10 healthcare industry brand loyalty is very, very significant.  
11 You're talking about people's healthcare, you're talking  
12 about access to drugs.

13 THE COURT: Are you talking across the board or in  
14 the PDP in particular?

15 THE WITNESS: I think across the board.

16 For example, this is my prescription drug card, and  
17 it is stamped in red with "CVS/Caremark" across the top. It  
18 is in the largest font on the card. And that indicates a  
19 significant recognition by the companies that their brand  
20 carries a lot of weight.

21 So an unwillingness of consumers to venture out to  
22 switch to a lesser known provider, for example, WellCare  
23 Health, would be a pretty significant consideration.

24 And if WellCare only has the ability to market under  
25 Aetna's brand for a year and then in less than two years

1 Aetna can reenter and start marketing again under their own  
2 name, that doesn't give WellCare Health very much time to do  
3 anything in terms of injecting competition into the market.

4 THE COURT: So do you agree with Dr. Sood that  
5 they're likely to believe as of now that they're not going to  
6 retain a high percentage of the customers that they have  
7 acquired?

8 THE WITNESS: I do. I think that's a really  
9 important analysis that Dr. Sood did, the retention analysis.  
10 And I think it is spot on, and it is very important to  
11 consider that. It will very likely not be a hundred percent  
12 retention rate.

13 BY MR. BALTO:

14 Q. Dr. Moss, you mentioned before that one of the  
15 alternatives would be simply to block the merger. A couple  
16 of years ago that happened in the Aetna-Humana merger. Judge  
17 Bates, evaluating the remedy in that merger, rejected it.  
18 How does the proposed remedy in that merger compare to the  
19 proposed remedy here?

20 A. So I think that there is a stark contrast between the  
21 two. Here you're talking about 2.1 million enrollees being  
22 assumed by WellCare Health. That, again, is 180 percent  
23 increase in what WellCare will have to absorb into its  
24 business very quickly.

25 In the Aetna-Humana case, the proposed divestiture of

1 almost 300,000 lives, covered lives, to Molina, the court  
2 concluded that it would not effectively restore competition.  
3 That is a mere fraction of the size of a divestiture as  
4 compared to the one that is being proposed here, and that was  
5 rejected, not only by the government, but by the Court, as  
6 well, in the Aetna-Humana merger, which was the number one  
7 reason why the merger was challenged and effectively blocked.

8 Q. Is there anything that has happened recently that  
9 perhaps raises your -- even beyond what you have testified so  
10 far that raises your concerns like any proposed acquisitions?

11 A. Sure. So it is in the news, only in the news that  
12 Centene will be acquiring WellCare Health or could -- is  
13 proposed to acquire WellCare Health. So a couple of things  
14 on that. One is it will create yet another vertically  
15 integrated insurer and PBM and integrated company. But for  
16 the purposes of the remedy, it is very troubling to hear the  
17 news that WellCare, so shortly after acquiring the assets,  
18 the PDP assets from Aetna, would be absorbed yet into another  
19 integrated healthcare organization. And the reason why  
20 that's concerning for the remedy is because that would be a  
21 very different animal than WellCare is right now. WellCare  
22 right now looks very differently than it would if it were  
23 merged into Centene. It would be a much larger integrated  
24 organization. It would have fundamentally different  
25 incentives and abilities to use those PDP assets to maintain

1       them or not to maintain them than the WellCare Health that we  
2       see today that is the proposed buyer of the PDP assets.

3               So having a big vertical merger quickly on the tails  
4       of this proposed divestiture I think changes the landscape  
5       fundamentally because you have very different incentives in  
6       that larger integrated organization and how those PDP assets  
7       would be maintained.

8       Q.       Okay. Is there anything else you want to say about  
9       the divestiture?

10      A.       That's all I have.

11      Q.       Okay. Great.

12              Let's move on to vertical concerns. Can you give the  
13      Court a sense -- I think you already have -- about why there  
14      are concerns from vertical acquisitions in healthcare and  
15      then what are those concrete concerns in this market.

16      A.       So I would observe that there are four major concerns  
17      surrounding vertical mergers and how they can affect  
18      competition and consumers. One is through the standard  
19      foreclosure theories, right, where you pair up an input  
20      supplier with a distributor or a manufacturer with a  
21      distributor. Now that firms are vertically integrated, they  
22      have assets that give them leverage or bargaining power over  
23      their rivals in two levels of market, an upstream market and  
24      down stream market. In this case, in CVS-Aetna, the  
25      potential foreclosure concerns are not only input

1 foreclosure, which would be potentially raising the costs or  
2 cutting off rival insurers' access to "must have" CVS  
3 pharmacies and PBM services, but also what we call customer  
4 foreclosure, which would essentially be denying rival  
5 pharmacies and PBMs the ability to get at Aetna as a  
6 potential customer. So the two foreclosure theories, as you  
7 know.

8 The second concern with vertical mergers is -- I've  
9 already alluded to -- is the creation of much higher barriers  
10 to entry, where with a bunch of vertically integrated firms,  
11 very difficult for any firm to enter at a single level. They  
12 have got to come in at multiple levels. And that really just  
13 -- scaling that wall would be very, very difficult.

14 Vertical mergers can also facilitate coordination  
15 amongst firms through information exchange between the  
16 upstream and the downstream affiliates, which I think we've  
17 heard about in some other vertical mergers. And then, of  
18 course, vertical mergers can eliminate potential competitors.

19 The concerns of the consumer groups here in this  
20 particular case fall most squarely on the foreclosure  
21 concerns, input foreclosure first and customer foreclosure.

22 Q. From the perspective of insurers, I gather so part of  
23 this is CVS will deny access to its pharmacies and it will  
24 screw up access to Caremark. So from the insurer's  
25 perspective, how crucial is access to an effective PBM?

1       A.       So I think it is well recognized that from an  
2 insurer's standpoint that having access to the depth and the  
3 scope of the CVS pharmacy and PBM networks is really  
4 essential to be able to compete in these markets.

5               Insurers want to offer that feature to their  
6 potential customers -- plan sponsors, pension funds, you name  
7 it -- that ultimately benefit the subscribers to those  
8 insurer plans.

9               So when a vertical merger occurs involving a "must  
10 have" asset, like the CVS pharmacies and PBM, we have to look  
11 really, really carefully and skeptically at the possibility,  
12 or we have to carefully assess the possibility that there  
13 would be enhanced incentives and ability to make it much more  
14 difficult for rival insurers to get access to CVS and Aetna.  
15 And that is the case -- that is the case here.

16              So the concern --

17       Q.       By the way, just pause for a second. You said get  
18 access. Maybe that creates an impression like, no, no, no,  
19 no, CVS won't allow anybody to have access to their PBM. Is  
20 it get access or is it more than that? Is it like providing  
21 inferior access?

22       A.       Of course, it is more than that. Thank you for that  
23 clarification.

24              So it is sort of a spectrum of possible concerns.  
25 One is they can -- they can do things, engage in behaviors



1       that make it -- that would raise the cost of rival insurers.  
2       They could just hassle them and engage in -- and I will go  
3       through a list of what potentially is on the table here.

4               THE COURT:   Could they require them to get their  
5       drugs only at CVS?

6               THE WITNESS:   Absolutely.

7               THE COURT:   Would that be legal or illegal, as far as  
8       you know?

9               THE WITNESS:   As far as I know, barring any legal  
10       constraint on that, I think the more powerful and the more  
11       market power CVS has through this merger or other mergers,  
12       the more attractive it becomes for them to force rival  
13       insurers into exclusive networks.

14              THE COURT:   If they didn't do that, could they at a  
15       minimum tell their customers that if you don't go to CVS,  
16       either your co-pay will be -- won't be a contribution from us  
17       or the co-pay will be much higher?

18              THE WITNESS:   Absolutely.   And that has actually  
19       happened.   About four years ago CVS engaged in an  
20       anti-smoking policy where they informed their customers,  
21       their Caremark customers, that if they purchased their drugs  
22       from a rival pharmacy that sold tobacco products that they  
23       would be -- they would pay a \$15 extra co-pay.

24              THE COURT:   Was that challenged as to its lawfulness?

25              THE WITNESS:   I don't know.   But I did not -- in

1       doing follow-up, I was not aware of any legal challenge to  
2       that.

3               THE COURT:   Interesting.

4               THE WITNESS:   But there are also other mechanisms.  
5       For example, in raising the cost of rival insurers or just  
6       frustrating access, which would be more of a full foreclosure  
7       kind of scenario, CVS-Aetna could develop formularies that  
8       exclude important drugs that are in demand by subscribers of  
9       rival health insurers.

10              Dr. Sood articulately outlined the lack of  
11       transparency and the failure, for example, to pass on rebates  
12       to rival health insurers.

13              They could design their pharmacy networks in a way  
14       that excludes important options like specialty pharmacies.  
15       That's key.

16              As you mentioned, they could force their rival  
17       insurers into exclusive CVS/Caremark networks.

18              They can use information that they gather about rival  
19       subscribers and drug spend to impair their ability to  
20       compete, to beat them to the punch, for example, on new  
21       marketing plans, targeting certain segments of their customer  
22       base.  And then certainly, you know, the ultimate would be to  
23       simply deny to fill prescriptions for their rival -- for  
24       rival insurers.

25              So it is troubling that there is such a robust list

1 of mechanisms through which CVS and Aetna could effectively  
2 foreclose rival health insurers. And again, it is critically  
3 important in this case to recognize that high levels of  
4 concentration -- high levels of concentration -- are really,  
5 really -- really, really important. Right? If rival  
6 insurers can't get access to CVS, who do they turn to? Who  
7 do they turn to, to avoid any sort of anti-competitive  
8 conduct by the merged company?

9 You don't need complicated economics to figure that  
10 out when options are so limited by high concentration that  
11 that is determinative of an anti-competitive, anti-consumer  
12 effect.

13 BY MR. BALTO:

14 Q. Let's step back for just a second here. By exclude,  
15 you don't mean totally exclude, it could also mean providing  
16 discriminatory access or harming them in some other fashion;  
17 right?

18 A. Correct.

19 Q. I'm sure that the nice witnesses tomorrow will tell  
20 the Court that these insurers are really bright and they  
21 could detect those strategies and easily switch to another  
22 PBM.

23 What is wrong with that theory that they could easily  
24 detect those strategies, especially for something like PBM  
25 rebates and easily switch to another PBM?

1       A.       Well, I think a lack of transparency -- and Dr. Sood  
2 alluded to this earlier -- a lack of transparency in terms of  
3 whether health insurers even know they're getting the best  
4 deal from their PBM. Very hard to tell. There is really not  
5 much benchmarking in the industry in terms of whether the  
6 prices that an insurer pays are actually competitive or not.

7       THE COURT: Is there any research that indicates that  
8 the average insurer has ever heard of what a PBM is, or have  
9 any idea what a PBM is. Before I got this case, I never even  
10 heard the expression PBM. Never heard of it. I now know it  
11 is a major, major in this entity. But unless you're steeped  
12 in this area of business and law, you would never -- I don't  
13 think the average insured person would have any idea what a  
14 PBM is? They have no idea.

15       THE WITNESS: I think you're right. I think you're  
16 absolutely right.

17       But I would also add, just to flesh this out a bit,  
18 that the lack of transparency in the PBM industry, nobody  
19 knows how big the rebates are, do they ever get passed  
20 through to the final subscriber. All of this --

21       THE COURT: Congress doesn't require them to report  
22 any of this?

23       THE WITNESS: And this has triggered state level  
24 initiatives to combat this lack of transparency and the power  
25 that is held by the PBMs in this very murky -- very murky --

1 intermediary type --

2 THE COURT: They're the middlemen.

3 THE WITNESS: Exactly, they are the middleman, for  
4 sure.

5 BY MR. BALTO:

6 Q. In fact, Dr. Moss, PBMs have restricted pharmacies  
7 from being able to disclose lower cash prices, as we heard  
8 today.

9 Let's go on to the customer foreclosure concerns.  
10 Why does access to customers matter for rivals?

11 A. So the customer foreclosure theory, which you don't  
12 hear as much about in vertical mergers because it is  
13 different and it assumes a very different fact pattern, the  
14 story would go something like: Because CVS now has this  
15 killer asset in the form of Aetna as a health insurer and  
16 Aetna could conceivably go out and contract with -- an  
17 unintegrated Aetna could go out and contract with any  
18 pharmacy or any PBM, the logic goes that, now integrated,  
19 this very important Aetna asset could be essentially withheld  
20 from the market in the fashion that CVS-Aetna would refuse to  
21 deal or decline to deal with rival pharmacies and PBMs. And  
22 that's a problem. That's an absolute problem. And again,  
23 there are many mechanisms that could be utilized to engage in  
24 customer foreclosure. And of course, the concern is, if that  
25 frustrates competition in the pharmacy and in the PBM markets

1 by taking Aetna off the table as a potential customer, then  
2 prices will go up, drug prices will go up because there is  
3 less competition in the upstream markets.

4 So, again, mechanisms that could be deployed to carry  
5 out a customer foreclosure theory would be forcing Aetna  
6 subscribers to convert to CVS/Caremark mail order, this is  
7 the exclusive networks problem that you just referred to.  
8 They could refuse to grant rival PBMs' affiliations to serve  
9 Aetna subscribers. That's a necessity to be able to actually  
10 do business with a health insurer. They could drive down  
11 dispensing fees for the independent pharmacies. They could  
12 delay reimbursements to smaller rival pharmacies. They can  
13 cherry-pick profitable prescriptions, take the most  
14 profitable for themselves and leave the smaller rivals with  
15 the very unattractive low-margin prescriptions. They can go  
16 through yet another set of activities or forms of conduct  
17 that would make it very difficult for rival PBMs and  
18 pharmacies to get access to Aetna. And of course, that would  
19 impair competition in the pharmacy PBM market, and input  
20 foreclosure would impair competition in the health insurer  
21 market.

22 And these are, as I said, very, very concentrated  
23 markets with very few options for the impacted consumers,  
24 businesses to switch to any other viable option. And that's  
25 why high concentration matters.

1 Q. How does high concentration in the health insurance  
2 market make this more problematic?

3 A. So when you have high concentration in the health  
4 insurance market, there are very few -- there are very few  
5 options for consumers, for example, who are the victims of an  
6 input foreclosure strategy to turn to. Right? So if the  
7 market was really well ventilated and we had 10 rival --  
8 robust rivalry between 10 health insurers, very few of these  
9 foreclosure concerns would arise in any vertical merger. If  
10 we had lots of competition in retail pharmacy and PBMs,  
11 foreclosure concerns are minimized, if not eliminated  
12 completely. It is only when high concentration matters, and  
13 switching options are very limited, and consumers are locked  
14 in to one provider, one pharmacy network or PBM network, and  
15 one health insurer network that really prompts these concerns  
16 about effective highly likely types of foreclosure.

17 I would also like to point out that the DOJ in their  
18 competitive -- in their response to the public comments in  
19 this proceeding fairly swiftly dismissed the foreclosure  
20 concerns. So, in the context of -- pardon me, Your Honor,  
21 I'm looking for --

22 THE COURT: Take your time.

23 THE WITNESS: -- the correct page.

24 It's in here somewhere.

25 THE COURT: Why don't you just paraphrase it. Give

1 me your recollection of it in general. If you find it  
2 later --

3 BY MR. BALTO:

4 Q. Look at slide 17, Dr. Moss.

5 A. Here we go. I'm sorry. Apologies.

6 I should have a staple. These aren't stapled  
7 together. Staples are very useful.

8 THE COURT: You have five minutes left. I wouldn't  
9 worry about it too much.

10 THE WITNESS: Let's go back to input foreclosures.  
11 Concerns that post-merger CVS and Aetna have enhanced  
12 incentives and abilities to foreclose their rival insurers  
13 from access to these "must have" networks. There is very  
14 little transparency in DOJ's explanation for why that is not  
15 a concern. They state two reasons for that. One is that it  
16 would be unprofitable for them to cut off or frustrate rival  
17 insurers' access to CVS because they would lose the business.  
18 They would just lose the business. And their insurer rivals  
19 switching to other PBMs and pharmacies are significant enough  
20 to make this an unprofitable strategy.

21 And the second part of the rationale, according to  
22 DOJ, as I read it, is Aetna's inability to capture those  
23 customers who are on the short end of the stick because now  
24 they can't get access to a really "must have" input that  
25 Aetna can't capture those customers.



1 I find, as an economist who studies this stuff 24/7,  
2 I find that to be a very murky and ill-supported rationale  
3 for why the Court should not consider -- why the government  
4 did not consider input foreclosure, and I think it really  
5 deserves a hard look.

6 Of course, we don't have access to confidential  
7 documents that were produced in an investigation. We do all  
8 of our analysis on the basis of publicly available  
9 information.

10 But just to finish up this theme, DOJ's logic as to  
11 why customer foreclosure is not a concern in this case,  
12 meaning cutting off Aetna from rival PBMs and rival  
13 pharmacies, is that it is unlikely because Aetna's relatively  
14 small share in the commercial insurance markets -- because  
15 Aetna has a small share in the commercial insurance  
16 markets -- I have trouble with that, significant trouble with  
17 that because Aetna competes in more than just commercial  
18 insurance markets. They compete in Medicare Advantage. They  
19 have other insurance products. It doesn't matter that they  
20 have a small share in commercial markets. Any of their  
21 insurance products are going to need to have inputs from  
22 pharmacy and from PBM services. So I found just reading the  
23 government's comments, response to the comments, I found that  
24 to be -- to lack a lot of transparency and clarity as to why  
25 that was a reason why we should not worry about customer

1 foreclosure.

2 Q. So those two sentences on vertical foreclosure don't  
3 give the Court much guidance about why there aren't concerns?

4 A. Correct.

5 Q. Going back to the pharmacy-related concerns, is there  
6 any other information you've recently gathered that sort of  
7 raised your concerns over pharmacy-related issues?

8 A. Well, I think, to return to the theme of Centene, the  
9 proposed or possible Centene-WellCare Health merger we would  
10 have yet another vertically integrated -- another vertically  
11 integrated insurer, pharmacy provider. Probably that would  
12 be fourth or fifth in the lineup. They would be the fourth  
13 or fifth largest firm.

14 Q. Going back to the concerns of Dr. Wohlfeiler, do you  
15 think those concerns are more general or unique to AHF?

16 A. No, I think they're much more -- they are  
17 generalizable to, not only at-risk populations that he so  
18 clearly articulated, but to any populations. And to come  
19 full circle, we're talking about consumers in this case in  
20 the PDP markets who are senior citizens, who are low-income  
21 consumers, who are sometimes at-risk individuals. And those  
22 impacts are really significant. And we're also talking  
23 about, not only those consumers, but the effects of higher  
24 costs and higher premiums and higher rates on taxpayers who  
25 fund the Medicare Part D programs.

1           In terms of the vertical concerns, I think the  
2           impacts would be on all of us. All of us would face  
3           significantly higher premiums, higher drug costs, as a result  
4           of this merger but, more generally, this sort of fundamental  
5           restructuring in the industry that this merger really  
6           contributes to.

7           Q.       So will competition be fully restored and consumers  
8           be protected if the Judge signs the proposed Final Judgment?

9           A.       I do not think they would be at all. I think  
10          consumers would be greatly -- competition would be  
11          imperilled, and consumers would be greatly at risk.

12          THE COURT: Thank you, ma'am.

13          THE WITNESS: Thank you.

14          THE COURT: You may step down.

15          (Witness excused)

16          THE COURT: All right. Counsel, we'll reconvene  
17          tomorrow morning at 10:45. We will hear from CVS, the  
18          government's, and Aetna's three witnesses.

19          I believe your first witness is the two-hour witness;  
20          isn't that correct?

21          MR. PITT: Yes, Your Honor.

22          THE COURT: We will hear from that one first. We  
23          probably won't finish it before lunch, but we might, it's  
24          possible. And then we will hear from the other two witnesses  
25          in the afternoon.

1           So I will see you in the morning.

2           Mr. Habash, come up.

3           (Bench conference not reported)

4           (Proceedings adjourned)

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## 1 CERTIFICATE OF OFFICIAL COURT REPORTER

2  
3 I, Patricia A. Kaneshiro-Miller, certify that the  
4 foregoing is a correct transcript from the record of  
5 proceedings in the above-entitled matter.  
6  
7

8 /s/ Patricia A. Kaneshiro-Miller

June 4, 2019

9 PATRICIA A. KANESHIRO-MILLER

DATE

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